Kansas Health Insurance Information System

Technical Manual

Second Edition

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I. SCOPE AND PURPOSE

During the 1994 Legislative Session, the Kansas Legislature passed statutes authorizing the Kansas Insurance Department (KID) to create a statistical plan, the Kansas Health Insurance Information System (KHIIS), to contain health insurance data, K.S.A. 40-2251. The Kansas Department of Health and Environment (KDHE) is serving as the statistical agent for the purpose of gathering, receiving and compiling data required by the plan. The objectives of the statistical plan are to determine if rates are reasonable in relation to benefits provided and to identify benefits or provisions that may be unduly influencing health insurance costs. To achieve this goal demographic information, insurance coverage provisions, and claims information is being collected for all covered lives in Kansas (see Appendix A for supporting legislation).

II. GENERAL RULES FOR SUBMISSION OF DATA

A. Time Frame Requirement for Data Submissions
   1. Data is to be submitted to KDHE on a quarterly basis. Data is due to KDHE within 105 days from the end of the calendar quarter. Therefore, data submitted for the quarters ending March 31, June 30, September 30 and December 31 are to be submitted on or before July 15, October 15, January 15, and April 15, respectively.
   2. Insurers may make arrangements with KDHE to provide data more frequently during the quarter. Upon receipt of a written request for an extension of the due date KDHE may for good cause, extend the time period for a particular reporting period. To make arrangements or for other questions, contact KDHE/KHIIS staff at (785) 368-7394 or (785) 296-8627.

B. Data should be submitted in one of the following media:

Type	Character Code	Density	Format	Data Label
Reel Tape	EBCDIC	1600 or 6250 bpi		Volume Number
8MM	EBCDIC	2gb, 5gb, or 7gb		Volume Number
½" Cartridge (Not preferred)	EBCDIC	6250 bpi	Compressed	Volume Number
3 1/2" PC Diskette	ASCII	1.44 MB	ASCII Fixed	Volume Number
CD ROM	ASCII	650 MB	ASCII Fixed	Volume Number

Note: Do not combine record types in a file. Each record type should be in a separate file.

C. Data submitted shall conform to the Standard Record Layout as specified by KDHE (see Appendix B).

D. Each data submission is to be accompanied by a completed and signed Kansas Health Insurance Information System Data Submission Form (see Appendix C).

E. A data dictionary is to be provided with the first data submission and amended as needed. The data dictionary provides information pertaining to the content of some of the variables requested and document exceptions. For example:
   - Product Description may be used to identify company specific plans that cannot be fully differentiated through use of the Plan Type and Product Type variables.
   - The Special Coverage Codes variable is included to provide flexibility in identifying products and coverage. Special Coverage Codes are defined by the insurer to define coverage plans in lieu of delineating specific items under the plan provisions.
   - Special situations:
     - Describe how a value is calculated or derived in a manner different from that described in the manual.
     - When for a compelling reason an exception, in the layout or definition of a variable, is granted by KDHE and/or Kansas Insurance Department staff.
     - To clarify terminology used to describe the companies data elements.

F. The insurance company is responsible for correcting errors or omissions in the data submitted. Once errors have been identified by KDHE, KID or the insurer the corrected data should be submitted to KDHE for inclusion in the KHIIS system. These corrected data submissions should be identified as resubmissions of existing data for the company.

G. Every insured and/or certificate holder, eligible for coverage at any time during the reporting period, must be included in the Membership Record, even if no claims have been filed against the policy.

H. Reporting Instructions
   1. Data submitted should include only claims associated with Kansas residents.
   2. Data submitted should include claims incurred, claims paid, adjusted, or amounts applied to patient liability (including co-pay, coinsurance, or deductible) during the reporting period.

III. INSTRUCTIONS FOR PREPARING DATA

A. The Member ID (MBRID) is to be a 20 character unique identifier that will permit information pertaining to a specific individual in any of the three files to be identified, linked, and analyzed. The Member ID is to be constructed in such a manner that the leftmost 18 characters may be used to group members into families. For this purpose a family is defined as a group of persons including one primary insured and covered dependents (including spouse and children). The premium for all members of a family should be included in the premium for the primary insured individual. The Member ID is the primary record level identifier. To illustrate creation of a Member ID:

1. Select a unique identifier (A) for the primary insured individual (e.g. social security number or other unique identifier, which may be encrypted). The resulting identifier (A) is to be 18 characters long and right justified with leading zeros to fill as needed. The primary insured's identifier is to be applied to all family members.
2. Assign a unique identifier to each family member. This identifier (B) is to be 2 characters long and right justified with a leading zero as needed.
3. Concatenate the two character strings above into a Member ID as:

   A || B
4. The member ID will be needed for longitudinal tracking of a member, that is through time. Therefore, the Member ID must be prepared consistently for each data submission so the member can be tracked from the initial enrollment to disenrollment. This number should not be reassigned.

B. Key Fields to Enable Relating Records between Files

To make full use of all information it is necessary to match record level information from the membership file to information in the summary file and the detail file. To permit relating records it is necessary to have the Member ID, described previously, and the Claim Number prepared consistently in all files. The inability to relate records using the Member ID and Claim Number will be considered an error and be cause for KDHE to request data be resubmitted.

	Membership	Summary	Detail
Primary Key	MBRID (Membership ID)	MBRID (Membership ID)	MBRID (Membership ID)
Secondary Key	N/A	CLMNO (Claim Number)	CLMNO (Claim Number)

Please see the glossary for variable definitions.

C. Numeric data, for purposes of the KHIIS database, includes dates, financial variables, and percentages.
   1. Dates should be submitted in the format CCYYMMDD where CC=century, YY=two digit year, MM=numeric month, and DD=day of month. All dates are eight digits long with no decimals.
   2. Financial variables are of varied lengths as needed to accommodate data. The number included in the data submission should not contain a decimal point; decimal points are implied characters. The length and number of digits to the right of the decimal point is indicated in the record layout tables under the column heading LEN. The total length of the variable, including decimal digits, is given by the number left of the decimal and the number of decimal places is indicated by the number right of the decimal in this column.
   3. Percentage fields are all 3 digits in length with two decimals as indicated by the length 3.2 in the LEN column of the record layouts.

D. Identifying Insurance Coverage and Allocating Coverage Provisions in the Membership File

   1. The KHIIS membership file is intended to identify the insurance coverage for each individual included in the database. For persons with health/medical coverage (Product Type = 1) the objective is to have a single record created that captures the health insurance Plan Type (valid Plan Type 1,2,3,or 4) and indicates whether the plan includes drug or dental coverage by using the appropriate drug and dental coverage indicators. To accomplish this, please use the following algorithm:

      a) If an individual has medical/health insurance without drug or dental coverage indicate this as:

Variable Name	Variable Number	Variable Value
Product Type	9	1
Drug Coverage Indicator	11	N
Dental Coverage Indicator	12	N

      b) If an individual has medical/health insurance with drug but no dental coverage indicate this as:

Variable Name	Variable Number	Variable Value
Product Type	9	1
Drug Coverage Indicator	11	Y
Dental Coverage Indicator	12	N

      c) If an individual has medical/health insurance with dental but no drug coverage indicate this as:

Variable Name	Variable Number	Variable Value
Product Type	9	1
Drug Coverage Indicator	11	N
Dental Coverage Indicator	12	Y

d) If the individual has medical/health insurance with drug and dental coverage indicate this as:

Variable Name	Variable Number	Variable Value
Product Type	9	1
Drug Coverage Indicator	11	Y
Dental Coverage Indicator	12	Y

2. Supplemental Plans (designated as Plan Type = 5) are those which provide additional benefits within the same product line(s) an individual is already covered, either from the same or a different payer. These include but are not limited to Medicare supplement plans. Using a Medicare Supplemental Medical/Health Plan as an example the Membership Record should be constructed as follows:

Variable Name	Variable Number	Variable Value
Product Type	9	1
Drug Coverage Indicator	11	as appropriate Y/N
Dental Coverage Indicator	12	as appropriate Y/N

Note: Supplemental Plans require further definition than is provided for in the coding of the Membership Record. Supplemental plans written for Kansas residents must be defined in the data dictionary. The variable Product Description may be used to differentiate between similar Supplemental Product Types (i.e. Medical/Health). Continuing with the Medicare Supplemental Plan(s) as an example it is necessary to differentiate between the various plans such as:

- Basic Medicare Supplemental Plans which cover copays and deductibles only
- Medigap Plans which cover the differences between the provider billed amounts and Medicare allowed amounts in addition to the copay and deductibles covered under the most basic Medicare Supplemental plan
- Medicare Exclusion Rider Plans for Medicare eligible persons still employed increase coverage to a level equal to that available through the employer group plan.

3. For persons with only Ancillary coverage(s), and no health insurance from the same insurer, the Product Type should be designated as an ancillary plan or other coverage (Product Type 2, 3, 4, 5 or 6) with the Plan Type = 6. Also, provide an appropriate response in the Drug and Dental Coverage Indicator variables to indicate if drug or dental coverage is included within the ancillary plan. For example:

a) If the individual has an ancillary prescription drug policy the record should be as follows:

Variable Name	Variable Number	Variable Value
Product Type	9	2
Drug Coverage Indicator	11	Y
Dental Coverage Indicator	12	N

b) If the individual has an ancillary dental service policy the record should be as follows:

Variable Name	Variable Number	Variable Value
Product Type	9	3
Drug Coverage Indicator	11	N
Dental Coverage Indicator	12	Y

c) If the individual has an ancillary cancer, hospitalization, or other policy the record should be as follows:

Variable Name	Variable Number	Variable Value
Product Type	9	4 (5 or 6)
Drug Coverage Indicator	11	N
Dental Coverage Indicator	12	N

4. The premium for each product should be recorded in the monthly premium field corresponding to the Member Status (MBRSTS) = 1, for the particular coverage. In other words, the monthly premium for each product listed should be recorded in the monthly premium field corresponding to the primary insured (MBRSTS=1). The premium should include the cost of coverage for the particular product for all family members. No premium should be recorded in association with dependent membership records.

IV. Data Validation

Following receipt and processing the data will be analyzed to assess the content of the submitted files. Feedback will include a completed Data Assessment Checklist Form (see Appendix D) and a narrative summary of questions and concerns.

V. CONFIDENTIALITY

The privacy of individual patients, providers and insurers is of utmost importance to the Kansas Health Insurance Information System (KHIIS). In order to ensure privacy is maintained, several steps have been taken (see Appendix A for statutes and regulations).

A. KID will not allow the identification of patients to be disclosed. All direct identifiers and characteristics that may lead to identification will be omitted from data released. Any identification, attempt at identification, or disclosure of a person is in violation of the confidentiality provisions of KHIIS.
B. Certain protections are available to providers and insures K.A.R. 40-1-45 specifies protection of information in the KHIIS database.
C. Individual company level data provided to KDHE and KID is protected from public release under the Uniform Trade Secrets Act if it is designated by the company as trade secrets (K.S.A. 60-3320). Those elements that can be protected are: Total Charge, Total Allowed, Total Paid, Line Item Charge, Line Item Allowed and Line Item Paid. Any additions to the protected element list must be justified and are subject to approval by KID. A written letter requesting such protection must be sent to KID in order for any of the data to be covered by the trade secret clause.
D. In any aggregate release of data, to protect confidentiality, a minimum number of patients or providers must be included. In following the recommended policy of the Health Care Data Governing Board, for statistical purposes all cells must contain a minimum of six (6) cases.
E. Data for small areas will be released only after approval by KID and through aggregate reports.
F. The insurance company will assign an encrypted identification number to providers. The provider number is to be assigned by the payer, with the exception of hospitals who are identified by their Medicare ID number.

VI. STANDARD REPORTS

KID and KDHE will be producing standard reports from the data collected. These reports will be generated at different intervals. Aggregate reports that include data from all contributors will be made available to the contributing companies, the legislature and to the public. Reports generated on a individual company basis will only be distributed to that company. Standard reports to be produced include:

A. NAME: Comparison of Kansas Medical Procedures Against National Norms
PERIODICITY: Annually
RECIPIENTS: Companies, legislature, public

B. NAME: Utilization Comparison to Standards Report
PERIODICITY: Annually
RECIPIENTS: Companies

C. NAME: Cost Per Unit Comparison to Standards Report
PERIODICITY: Annually
RECIPIENTS: Companies

D. NAME: Cost Per Unit Comparison to Standards Report
PERIODICITY: Annually
RECIPIENTS: By policy or Company: company; by aggregate: companies, legislature, public

E. NAME: Trend Reports
PERIODICITY: Quarterly
RECIPIENTS: Companies

F. NAME: Benefit Ratio
PERIODICITY: Annually
RECIPIENTS: Companies

G. NAME: Form Loss Ratio Report
PERIODICITY: Upon rate filing or on request by the KID.
RECIPIENTS: Companies

H. NAME: Quality Report
PERIODICITY: Annually
RECIPIENTS: Companies

VII. REQUESTS FOR SPECIAL REPORTS OR DATA

If the desired information is not available in the standard reports special reports may be requested. Also, data may be made available to persons or agencies wanting to use portions of the KHIIS data to augment studies.

A. All data requests for KHIIS data must be submitted on the Public Use Data Request Form or the Restricted Data Request Form obtained from KDHE (see Appendix E).
B. If requested data cannot be obtained through standard reports, a Restricted Data Request Form must be used. Data requests must be approved by KID.
C. The data request must state the name of the requestor, the business name and address, and kind of business.
D. The data request must detail which data elements or reports are needed.
E. All data requests must be accompanied by a statement specifying the purpose for which the data are needed.
F. All reports, tapes, diskettes, etc. using information from KHIIS must be approved by KID.
G. Before data is released, the customer must sign a form accepting responsibility for its use. A standard form will be made available to the customer by KID. Whether the data will be released for public or restricted use is at the discretion of KID.
H. The fee schedule will be provided and must be adhered to by all persons requesting data from KHIIS. The fee schedule will be set annually by KDHE.
I. Records of data requests will be maintained. The records will note who data users are and the frequency of their requests.

Glossary

General Terms

CHES: Center for Health and Environmental Statistics

Insurers: Accident and Health carriers providing coverage for Kansas residents as defined in K.S.A. 40-202c

KDHE: Kansas Department of Health and Environment

KID: Kansas Insurance Department

OHCI: Office of Health Care Information within KDHE

Variable Definitions

Common Variables

Group Number: A number, which may include both alpha and numeric characters, that identifies a group of individuals belonging to a health plan.

Member Status: This designates the covered person as one of three possibilities; the primary insured (active member or subscriber), the spouse of the primary insured individual, and dependents of the primary insured.

Membership ID: This is a unique identifier assigned to each insured individual. The content of this field should also permit grouping individuals into families that are covered under a given policy (Please see Instructions for Preparing Data.).

Patient ID Number: This is the last four digits of the individuals Social Security Number. If this is not available the field should be left blank.

Payer Number: The insurer as identified by the company=s NAIC Number. Also may be referred to simply as payer.

Membership File Variables

Benefit Payment per Day: The maximum benefit the insurer will pay on behalf of the beneficiary per day for medical/health or other type of insurance coverage.

Dental Coverage Indicator: If a member has dental care coverage included in the monthly premium for the medical/health insurance plan this indicator should equal AY@ for Yes. If dental care coverage is through an ancillary dental plan, with a separate premium, this field should equal AY@ for Yes and the dental plan detailed in the record with the plan type, product type, monthly premium, and plan provisions. If dental coverage is not included in the health/medical plan the value for this field should be AN@ for No.

Drug Coverage Indicator: If a member has prescription medication coverage included in the monthly premium for the medical/health insurance plan this indicator should equal AY@ for Yes. If prescription coverage is through an ancillary drug plan, with a separate premium, this field should equal "Y" for Yes and the drug plan detailed in the record with the plan type, product type, monthly premium, and plan provisions. If drug coverage is not included in the health/medical plan the value for this field should be AN@ for No.

Eligible Months in Reporting Period: This is the number of months, within the reporting period that an individual is eligible for insurance benefits for the corresponding plan. This is calculated as follows:

Eligible Months = [(Reporting Period Ending Date) - (Reporting Period Starting Date) / (365.25 days per year /12 months per year)]

For example, quarterly submissions will range from one to three months and yearly submissions will range from one to twelve months.

Eligibility Period Ending Date: This is either the Period Ending Date, as found in the header file, or the last date an individual was covered by the insurance plan, whichever is the first or earliest date. This may vary among plans in the event an individual drops coverage at some point during the reporting period.

Eligibility Period Starting Date: This is either the Period Beginning Date, as found in the header file, or the first date an individual was covered by the insurance plan, whichever is the latest or most recent date. This may vary among plans in the event an individual elects different or additional coverage at some point during the reporting period.

Monthly Premium: The premium attributed to providing all coverage(s) for an individual and dependents (spouse and/or other dependents).

Product Description: is used to identify company specific plans that cannot be fully differentiated through use of the Plan Type and Product Type variables.

Special Coverage Codes: are defined by the insurer to define coverage plans in lieu of delineating specific items under the plan provisions. These must be defined in the data dictionary and a reference table (database or spreadsheet) provided.

Plan Provisions: Based on the plan type, product type, and monthly premium, insurance policies may incorporate a combination of the following criteria in defining the individuals or families responsibility in paying for health care services used. These provisions may vary depending on the type of service.

Dental Services

Dental Individual Deductible: The total out of pocket dental expense an individual is responsible for within a plan year before the insurer pays the full cost of dental services excluding co-payments and co-insurance when applicable (Variables 48, 53, 58, 63, 68).

Dental Family Deductible: The total out of pocket dental expense that a family would incur within a plan year before the insurer pays the full cost of dental services excluding co-payments and co-insurance when applicable (Variables 49, 54, 59, 64, 69).

Dental Individual Co-insurance: The maximum amount of co-insurance, for dental services, an individual is responsible for within a plan year (Variables 50, 55, 60, 65, 70).

Dental Family Co-insurance: The maximum amount of co-insurance, for dental services, a family is responsible for within a plan year (Variables 51, 56, 61, 66, 71).

Dental Co-insurance Percent: The proportion of the cost of dental services that is the member's responsibility to pay. This is commonly reported as a percentage. For the KHIIS database report the proportion or fractional amount rather than as a percentage. For example for a 20% co-insurance is to be submitted as 020 (Variables 52, 57, 62, 67, 72).

Note: Provisions have been made to accommodate a variety of dental plans. Basic dental coverage plan provisions should be recorded in variables 48 through 52. If multiple dental plans are available with provisions differing from the basic coverage these should be recorded in variables 53 through 72 for plans A through D. The majority of companies providing dental coverage in Kansas will not use dental Plans A through D. For companies not submitting data in these fields we ask that you create dummy fields and fill them with zeros sufficient to match the file layout specifications.

Medical/Health

Maximum Individual Deductible: The total out of pocket expense that an individual is responsible for within a plan year before the insurer pays the full cost of services excluding co-payments and co-insurance when applicable (Variables 17, 23, 29, 35).

Maximum Family Deductible: The total out of pocket expense that a family would incur within a plan year before the insurer pays the full cost of services excluding co-payments and co-insurance when applicable (Variables 18, 24, 30, 36).

Co-pay: The preset, fixed dollar, amount that the individual is responsible for with each episode of care (Variables 19, 25, 31, 37).

Co-insurance: The proportion of the cost of health care services that is the member's responsibility to pay. This is commonly reported as a percentage. For the KHIIS database, report the proportion or fractional amount rather than a percentage. For example for a 20% co-insurance submit 020 (Variables 20, 26, 32, 38).

Maximum Individual Co-insurance: The maximum amount of co-insurance an individual is responsible for within a plan year (Variables 21, 27, 33, 39).

Maximum Family Co-insurance: The maximum amount of co-insurance a family is responsible for within a plan year (Variables 22, 28, 34, 40).

Note: Medical/Health coverage provisions is divided to capture coverages applicable only to facilities (variables 17 through 22), professional services (variables 23 through 28), other services (variables 29 through 34), and all services combined (variables 35 through 40). Facility coverages apply to services or goods provided by a facility and its staff such as a hospital, ambulatory surgery center, freestanding diagnostic center or other facility based charges. Professional Services are those provided by a health care professional, for example physicians, counselors and therapists and billed for separately. Other Services includes services other than those provided by a health care professional or facility based charges. Combined represents the sums of the respective provision for all medical/health care or, if the plan does not differentiate the provisions according to facility professional or other services, the unified plan provisions.

Prescription Drug

Drug Co-pay Amount - Generic: The preset, fixed dollar, amount that the individual is responsible for each generic drug prescription (Variable 41).

Drug Co-pay Amount - Brand Name: The preset, fixed dollar, amount that the individual is responsible for each brand name drug prescription (Variable 42).

Drug Co-pay Percent: The proportion of each prescription drug charges the individual is responsible for. For the KHIIS database report the proportion or fractional amount rather than as a percentage. For example for a 20% co-payment is to be submitted as 020 (Variable 43).

Drug Individual Deductible: The total out of pocket prescription drug expense an individual is responsible for within a plan year before the insurer pays the full cost of prescription drugs excluding co-payments and co-insurance when applicable (Variable 44).

Drug Family Deductible: The total out of pocket prescription drug expense that a family would incur within a plan year before the insurer pays the full cost of prescription drugs excluding co-payments and co-insurance when applicable (Variable 45).

Drug Individual Co-insurance: The maximum amount of co-insurance, for prescription medications, an individual is responsible for within a plans year (Variable 46).

Drug Family Co-insurance: The maximum amount of co-insurance, for prescription medications, a family is responsible for within a plans year (Variable 47).

Plan Types:

1. Indemnity Plan: Also known as fee for service plans, provide benefits in a predetermined amount for covered services. Health care providers are not employees of the company providing benefits nor have they contracted with the company to provide services for a predetermined cost to a set of individuals enrolled in the plan. With this type of health insurance the individual pays a proportion of costs (e.g. 20% of charges) after meeting a deductible for the year while the insurer pays the remainder of the cost. There may also be provisions for the maximum amount an individual pays annually. The company may also limit the yearly or lifetime benefits it will pay for an individual.

2. PPO (Preferred Provider Organization): A managed plan in which an insurer negotiates price discounts with health care providers to provide services to covered persons. These types of plans may make the individual responsible for coinsurance, co-payment, and deductibles. Services obtained from providers that have not contracted with the insurer are generally covered though the individual will generally be responsible for a larger portion of the cost through increased co-payments, coinsurance, and deductibles.

3. HMO (Health Maintenance Organization): An organization that provides a set of health services to a specified group of enrollees for a fixed periodic payment (i.e. monthly premium). HMOs are also referred to as Apre-paid@ or Acapitated@ plans. There are two primary models of HMOs; the staff or group model and the individual practice association (IPA) model. In the group or staff model services are provided at centralized medical offices or clinics by providers employed by the HMO. Health care providers participating in an IPA contract with the HMO to provide services to enrollees within their offices.

4. POS (Point of Service): Offered by HMOs point of service plans are similar to indemnity plans. The HMO network providers usually refer patients to providers contracting with the HMO though they may refer to providers outside the network. If the provider refers a person outside the network the costs are generally covered; if the person self-refers outside the network the individual may be required to pay a co-insurance.

5. Supplemental Policy: Insurance policy purchased to augment primary medical or other coverage(s). These policies pay for costs not covered by the members' primary insurance plan. The scope of coverage and scope of the population is to be defined in the data dictionary i.e., Medicare Supplemental policy identification.

6. Ancillary: An insurance product that covers health services not included in the medical care coverage plan for the individual and for which the monthly premium and coverage provisions are specified. When this plan type is used the corresponding Product Type should be identified as; 2=Ancillary Drug, 3=Ancillary Dental, 4=Ancillary Cancer, 5=Ancillary Hospital Confinement or 6=Other.

Product Type:

1. Medical/Health Coverage: This type of product provides coverage for, but is not limited to, medical services according to the specifications of the plan.

2. Drug: An additional policy for the sole purpose of covering drug expenses not covered under the Medical/Health Coverage.

3. Dental: An additional policy for the sole purpose of covering dental expenses not covered under the Medical/Health Coverage.

4. Cancer: An additional policy for the sole purpose of covering cancer treatment expenses not covered under the Medical/Health Coverage.

5. Hospitalization: An additional policy for the sole purpose of covering hospitalization expenses not covered under the Medical/Health Coverage.

6. Other: Insurance products which cover services that are not included in either Medical/Health, Drug, Dental, Cancer, or Hospitalization Coverage.

Claim Detail File Variables

Attending/Prescribing Provider Type Code: Is a companion to the Attending/Prescribing Provider Number to indicate the role of the provider in the care process. Valid responses include: 1=Attending Physician; 2=Prescribing Physician; and 3=Pharmacy.

Attending/Prescribing Provider Number: The provider number assigned by the insurer. This may be encrypted for privacy.

Brand Name Indicator: Used only for claim line items that are prescription medications to denote whether the product is either a name brand or a generic medication. This will be assigned by KDHE from a standard reference table. Please fill this field with blanks.

Capitation Agreement: Indicates, through a AY@ = Yes AN@ = No response, whether this procedure is covered by a capitation agreement.

Co-Insurance: This variable, field 30, as used in the context of this manual is defined as co-payment plus coinsurance for each item in a claim. Co-insurance and co-payment have been combined into a single variable because of variability in the definition and application of these terms.

> **Co-Insurance:** This is the amount an individual is responsible for after meeting their deductible requirements as specified in their policy. This is often a percentage of the charges (total or allowed depending on the type of plan).
> **Co-Payment:** This is a predetermined fee an individual is responsible for each of the services an individual uses. This is generally a flat fee per service rather than a percentage.

Date Paid: The date the claim was paid, the amount was applied to the deductible or other accounting process to close this line item.

Deductible: The dollar amount incurred for a specific service applied to the deductibles according to the plan provisions.

Increment Line Item Number: This counts the individual items applicable to a claim.

Line Item Allowed: This field captures the eligible amount for the service in the insurance company contract.

Line Item Charge: The amount billed for the service.

Line Item Paid: This is the amount actually paid by the company for the service.

Place of Service: This is the type of place, as defined in Appendix F: Code Table 2, where services were provided.

Primary Diagnosis: The ICD-9 Code indicating the primary condition a patient is receiving treatment for within an claim. This code should correspond to the ICD-9 Diagnosis Code in the summary file for the corresponding claim.

Provider Location: The five-digit zip code of the office, clinic or facility in which services are received.

Provider Number: For hospitals this is the Medicare number, other providers will have numbers assigned by the payer.

Provider Type Code: Identifies a provider as either a health care professional or an institutional provider.

Revenue Modifier: This is included to identify the type of Revenue/Procedure Code included in the claim detail record. Valid values for this field are: 1=CPT-4 Codes; 2=Revenue Codes; 3=HCPC Codes; and 4=NDC Codes.

Revenue/Procedure Code: The code for the appropriate procedure code for the service provided is placed in this field. The type of code is identified by the Modifier, see definition of Revenue Modifier. Valid code types are: CPT-4 Codes, Revenue Codes, HCPC Codes, and NDC Codes.

Secondary Diagnosis: The first supplemental diagnosis, which requires treatment with a claim.

Service Date: This is the actual date the service, as indicated by the Revenue/Procedure Code, is provided.

Specialty: This is the primary specialty of the health care professional providing services for a specific claim item. Please refer to Appendix F: Code Tables 1A – 1D for specialty coding.

Therapeutic Class Code: Used only for claim line items that are prescription medications to identify the class, or type, of drug. This will be assigned by KDHE from a standard reference table. Please fill this field with blanks.

Third Diagnosis: The second supplemental diagnosis, which requires treatment with a claim.

Units of Service: This is a measure of the amount of service that is provided to a patient. Report hospital days for inpatients, the quantity of pills (or other unit) prescribed for medications, and the appropriate units for other services.

Units of Service, Type: This is an indicator which identifies the Units of Service. Valid values are: 1=minutes; 2=hours; 3=days; 4=quantity.

Claim Summary File Variables

Claim Line of Business: This is the line of business for the health care professional or institution providing services included in this claim.

Coordination of Benefits: In the event of multiple coverages the coverage provided by the company submitting this claim should indicate whether they are the primary insurer, secondary insurer or other source of insurance coverage.

Discharge Status: This field applies only to inpatients, as identified in Claim Line of Business (Variable 21; LOB=1), and describes their discharge destination according to the codes provided in the KHIIS Technical Manual File Layout.

First Date of Service: The first date outpatient services are received on a claim or within an encounter. The admission date is to be used for inpatients.

ICD-9 Diagnosis Code: The primary diagnosis, which applies to the claim.

ICD-9 Procedure Code: The ICD-9 procedure code for the claim.

Last Date of Service: The last date outpatient services are received on a claim or within an encounter. For inpatients, the discharge date is to be used. If an inpatient has not been discharged at the end of the reporting period this field should be filled with a zero.

Resident County: The two letter county code for the county in which the individual resides. This will be assigned by KDHE from the Resident Zip Code. Please leave this field blank.

Resident Zip Code: The five-digit zip code in which the individual resides.

Total Paid: This is the amount actually paid by the company for the services associated with this claim.

Total Charges: This amount is the total charge for the services associated with the claim.

Total Allowed: This field captures the eligible amount for the services associated with a given claim.

Header File

Filename: This is the name a company assigns to a transport data file being submitted for inclusion in the database.

Period Beginning Date: This is the earliest date for which paid claims are included in the file.

Period Ending Date: This is the last date for which paid claims are included in the file.

APPENDIX A
Supporting Legislation

40-2251. Statistical plan for recording and reporting premiums and loss and expense experience by accident and health insurers; compilation and dissemination; secretary of health and environment to serve as statistical agent; assessments; penalties for failure to report. (a) The commissioner of insurance shall develop or approve statistical plans which shall be used by each insurer in the recording and reporting of its premium, accident and sickness insurance loss and expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the commissioner and other interested parties in determining whether rates and rating systems utilized by insurance companies, mutual nonprofit hospital and medical service corporations, health maintenance organizations and other entities designated by the commissioner produce premiums and subscriber charges for accident and sickness insurance coverage on Kansas residents, employers and employees that are reasonable in relation to the benefits provided and to identify any accident and sickness insurance benefits or provisions that may be unduly influencing the cost. Such plans my also provide for the recording and reporting of expense experience items which are specifically applicable to the state. In promulgating such plans, the commissioner shall give due consideration to the rating systems, classification criteria and insurance and subscriber plans on file with the commissioner and, in order that such plans may be as uniform as is practicable among the several states, to the form of the plans and rating systems in other states.

(b) The secretary of health and environment, as administrator of the health care database, pursuant to K.S.A. 1998 Supp. 65-6804, and amendments thereto, shall serve as the statistical agent for the purpose of gathering, receiving and compiling the data required by the statistical plan or plans developed or approved under this section. The commissioner of insurance shall make an assessment upon the reporting insurance companies, health maintenance organizations, group self-funded pools, and other reporting entities sufficient to cover the anticipated expenses to be incurred by the secretary in gathering, receiving and compiling such data. Such assessment shall be in the form of an annual fee established by the secretary and charged to each reporting entity in proportion to such entity's respective shares of total health insurance premiums, subscriber charges and member fees received during the preceding calendar year. Such assessments shall be paid to the secretary and the secretary shall deposit the same in the state treasury and it shall be credited to the insurance statistical plan fund. Compilations of aggregate data gathered under the statistical plan or plans required by this act shall be made available to insurers, trade associations and other interested parties.

(c) The secretary, in writing, shall report to the commissioner of insurance any insurance company, health maintenance organization, group self-funded pool, nonprofit hospital and medical service corporation and any other reporting entity which fails to report the information required in the form, manner or time prescribed by the secretary. Upon receipt of such report, the commissioner of insurance shall impose an appropriate penalty in accordance with K.S.A. 40-2,125, and amendments thereto.

History: L.1990, ch. 170, § 1; L. 1994, ch. 238, § 13; L. 1995, ch. 260, § 1; July 1.

K.A.R. 40-1-45. Release of data from the insurance database. (a) Although the data collected by and furnished to the commissioner of insurance pursuant to K.S.A. 40-22-51, and amendments thereto, is not an open record pursuant to K.S.A. 1997 Supp. 45-221(16), and amendments thereto, compilations of this data may be released, subject to the following limitations.

(1) These reports shall include comparative information on averages of data collected. Compilations of data shall not contain patient-identifying information or trade secrets.

(2) The raw data shall be released by the commissioner of insurance only to each data provider that has submitted that particular data to the database and that requests to see and review its database pertaining to that data provider. These datasets shall not be made available to the public.

(3) External data used for normative values that are not within the public domain shall not be released.

(b) Any person, organization, governmental agency, or other entity may request the request the preparation of compilations of data collected by and furnished to the commissioner of insurance, in accordance with the following procedure and limitations.

(1) All requests for compilations of data shall be made in writing to the commissioner of insurance. The written request shall contain the name, address, and telephone number of the requester, and a description of the legitimate purpose of the requested compilation. A "legitimate purpose" is defined as a purpose consistent with the intent, policies, and purposes of K.S.A. 40-2251, and amendments thereto. Whether or not a legitimate purpose exists may be determined by the commissioner of insurance.

(2) Each request for a compilation of data shall be reviewed by the commissioner of insurance to determine whether to approve or deny the request. A request for compilation of data may be denied by the commissioner of insurance for reasons including any of the following.

(A) The data is unavailable.

(B) The request compilation.

(C) The requested compilation of data would endanger patient confidentiality.

(D) The commissioner lacks sufficient resources to fulfill the request.

(E) The request would disclose a trade secret.

(F) The requester has previously violated the rules for dissemination from the insurance database.

(G) The request is not a legitimate purpose.

(3) The requester may ask for compilations of data collected by and furnished to the commissioner of insurance in a specific manner or format not already used by the commissioner. This shall include any request for subsets of information already available from the commissioner in compiled form.

(4) The requester shall be notified by the commissioner of insurance in writing of its decision within 30 days. Each denial of a request shall included a brief explanation of the reason for the denial.

(5) Determination of a fee to be charged to the requesting person, organization, governmental agency, or other entity to cover the direct and indirect costs for producing compilations shall be mad by the commissioner of insurance or designee in consultation with commissioner. The fee shall include staff time, computer time, copying costs, and supplies.

For charging purposes, each compilation shall be considered an original. The fee may be waived at the commissioner's discretion.

(c) No person, organization, governmental agency, or other entity receiving data from the commissioner shall redisclose or redistribute that information for commercial purposes. Any violation of this section shall result in denial of all further requests to the insurance database.

(d) Any publication using data from the insurance database shall include a written acknowledgement of the Kansas insurance department. A copy of any publication of data from the insurance database shall be sent to the commissioner of insurance before its publication. (Authorized by K.S.A. 1997 Supp. 40-2251 and K.S.A. 40-221; implementing K.S.A. 1997 Supp. 40-2251; effective Aug. 21, 1998).

Chapter 60.--PROCEDURE, CIVIL
Article 33.--ACTIONS RELATING TO COMMERCIAL ACTIVITY

60-3320. Definitions. As used in this act, unless the context requires otherwise:

(1) "Improper means" includes theft, bribery, misrepresentation, breach or inducement of a breach of a duty to maintain secrecy, or espionage through electronic or other means.

(2) "Misappropriation" means:

(i) acquisition of a trade secret of another by a person who knows or has reason to know that the trade secret was acquired by improper means; or

(ii) disclosure or use of a trade secret of another without express or implied consent by a person who

(A) used improper means to acquire knowledge of the trade secret; or

(B) at the time of disclosure or use, knew or had reason to know that his knowledge of the trade secret was

(I) derived from or through a person who had utilized improper means to acquire it;

(II) acquired under circumstances giving rise to a duty to maintain its secrecy or limit its use; or

(III) derived from or through a person who owed a duty to the person seeking relief to maintain its secrecy or limit its use; or

(C) before a material change of his position, knew or had reason to know that it was a trade secret and that knowledge of it had been acquired by accident or mistake.

(3) "Person" means a natural person, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

(4) "Trade secret" means information, including a formula, pattern, compilation, program, device, method, technique, or process, that:

(i) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use, and

(ii) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

History: L. 1981, ch. 214, § 1; July 1.

Chapter 65.--PUBLIC HEALTH
Article 68.--HEALTH CARE DATA

65-6801. Health care database; legislative intent; use of information. (a) The legislature recognizes the urgent need to provide health care consumers, third-party payors, providers and health care planners with information regarding the trends in use and cost of health care services in this state for improved decision-making. This is to be accomplished by compiling a uniform set of data and establishing mechanisms through which the data will be disseminated.

(b) It is the intent of the legislature to require that the information necessary for a review and comparison of utilization patterns, cost, quality and quantity of health care services be supplied to the health care database by all providers of health care services and third-party payors to the extent required by K.S.A. 1999 Supp. 65-6805 and amendments thereto and this section and amendments thereto.

(c) The information is to be compiled and made available in a form prescribed by the governing board to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services.

History: L. 1993, ch. 174, § 1; L. 1994, ch. 90, § 2; July 1.

65-6803. Same; health care data governing board created; appointment of task force or task forces; meetings and duties of the board. (a) There is hereby created a health care data governing board.

(b) The board shall consist of nine members appointed as follows: One member shall be appointed by the Kansas medical society, one member shall be appointed by the Kansas hospital association, one member shall be appointed by the executive vice chancellor of the university of Kansas school of medicine, one member who is a licensed professional nurse appointed by the Kansas state nurses association, one member representing health care insurers or other commercial payors shall be appointed by the governor, one member representing adult care homes shall be appointed by the governor, one member representing the Kansas health institute, one member appointed by the state board of regents representing the health services research community and one member representing consumers of health care shall be appointed by the governor. The secretary of health and environment, or the designee of the secretary, shall be a nonvoting member who shall serve as chairperson of the board. The secretary of social and rehabilitation services and the insurance commissioner, or their designees, shall be nonvoting members of the board. Board members and task force members shall not be paid compensation, subsistence allowances, mileage or other expenses as otherwise may be authorized by law for attending meetings, or subcommittee meetings, of the board. The members appointed to the board shall serve for three-year terms, or until their successors are appointed and qualified.

(c) The chairperson of the health care data governing board may appoint a task force or task forces of interested citizens and providers of health care for the purpose of studying technical issues relating to the collection of health care data. At least one member of the health care data governing board shall be a member of any task force appointed under this subsection.

(d) The board shall meet at least quarterly and at such other times deemed necessary by the chairperson.

(e) The board shall develop policy regarding the collection of health care data and procedures for ensuring the confidentiality and security of these data.

History: L. 1993, ch. 174, § 3; L. 1997, ch. 75, § 1; Apr. 17.

65-6804. Same; duties of secretary of health and environment; contract for data collection; system of fees; rules and regulations; data confidential; penalties for violations.

(a) The secretary of health and environment shall administer the health care database. In administering the health care database, the secretary shall receive health care data from those entities identified in K.S.A. 1999 Supp. 65-6805 and amendments thereto and provide for the dissemination of such data as directed by the board.

(b) As directed by the board, the secretary of health and environment may contract with an organization experienced in health care data collection to collect the data from the health care facilities as described in subsection (h) of K.S.A. 65-425 and amendments thereto, build and maintain the database.

(c) The secretary of health and environment shall adopt rules and regulations approved by the board governing the acquisition, compilation and dissemination of all data collected pursuant to this act. The rules and regulations shall provide at a minimum that:

(1) Measures have been taken to provide system security for all data and information acquired under this act;

(2) data will be collected in the most efficient and cost-effective manner for both the department and providers of data;

(3) procedures will be developed to assure the confidentiality of patient records. Patient names, addresses and other personal identifiers will be omitted from the database;

(4) users may be charged for data preparation or information that is beyond the routine data disseminated and that the secretary shall establish by the adoption of such rules and regulations a system of fees for such data preparation or dissemination; and

(5) the secretary of health and environment will ensure that the health care database will be kept current, accurate and accessible as prescribed by rules and regulations.

(d) Data and other information collected pursuant to this act shall be confidential, shall be disseminated only for statistical purposes pursuant to rules and regulations adopted by the secretary of health and environment and approved by the board and shall not be disclosed or made public in any manner which would identify individuals. A violation of this subsection (d) is a class C misdemeanor.

(e) In addition to such criminal penalty under subsection (d), any individual whose identity is revealed in violation of subsection (d) may bring a civil action against the responsible person or persons for any damages to such individual caused by such violation.

History: L. 1993, ch. 174, § 4; L. 1994, ch. 90, § 3; L. 1995, ch. 260, § 9; July 1. 65-6805.

65-6805. Same; medical, health care and other entities to file health care data; exception. Each medical care facility as defined by subsection (h) of K.S.A. 65-425 and amendments thereto; health care provider as defined in K.S.A. 40-3401 and amendments thereto; providers of health care as defined in subsection (f) of K.S.A. 65-5001 and amendments thereto; health care personnel as defined in subsection (e) of K.S.A. 65-5001 and amendments thereto; home health agency as defined by subsection (b) of K.S.A. 65-5101 and amendments thereto; psychiatric hospitals licensed under K.S.A. 75-3307b and amendments thereto; state institutions for the mentally retarded; community mental retardation facilities as defined under K.S.A. 65-4412 and amendments thereto; community mental health center as defined under K.S.A. 65-4432 and amendments thereto; adult care homes as defined by K.S.A. 39-923 and amendments

thereto; laboratories described in K.S.A. 65-1,107 and amendments thereto; pharmacies; board of nursing; Kansas dental board; board of examiners in optometry; state board of pharmacy; state board of healing arts and third-party payors, including but not limited to, licensed insurers, medical and hospital service corporations, health maintenance organizations, fiscal intermediaries for government-funded programs and self-funded employee health plans, shall file health care data with the secretary of health and environment as prescribed by the board. The provisions of this section shall not apply to any individual, facility or other entity under this section which uses spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination for the treatment or cure of disease.
History: L. 1993, ch. 174, § 5; L. 1994, ch. 90, § 4; July 1.

Appendix B
Standard File Layout

Header Record Layout

				DATA EXAMPLES		POSITION			FORMAT		
	ELEMENT	NAME	Valid Values	DISPLAY	SUBMITTED	LEN.	START	END	TYPE	JUST,	CONS.
1	NAIC Number	NAICNO	NAIC Number			5	1	5	C	L	I,E
2	Filename					10	6	15	C	L	I
3	Period Beginning Date		CCYYMMDD	January 1, 2000	20000101	8	16	23	N	R	I,E
4	Period Ending Date		CCYYMMDD	March 31, 2000	20000331	8	24	31	N	R	I,E
5	Record Count		Blank on header			9	32	40	N	R	

FORMAT

LEN. (length): Length or total length of the variable

START: Starting position of the field

END: Terminal position of the field

TYPE:

N=Numeric: Missing Values = Null Value
C=Character: Missing Values = Blank

JUST (Justification):
R=Right
L=Left

CONS (consistency): Consistency of the variable relative to internal or external references
E=External
I=Internal

Membership Record #1 Filename MBRSHP1

				DATA EXAMPLES		POSITION			FORMAT		
	ELEMENT	NAME	Valid Values	DISPLAY	SUBMITTED	LEN.	START	END	TYPE	JUST.	CONS.
1	NAIC Number	NAICNO	NAIC Number			5	1	5	C	L	I,E
2	Group Number	GRPNO	Group Number			9	6	14	C	L	I
3	Membership ID	MBRID	Unique Member ID			20	15	34	C	L	I
4	Patient ID Number	PATNO	Last 4 digits of SSN			4	35	38	C	L	I
5	Patient Date of Birth	PATDOB	CCYYMMDD	December 31, 1999	19991231	8	39	46	N	R	I,E
6	Patient Gender Code	PATSEX	1 = Male 2 = Female			1	47	47	C	L	I,E
7	Member Status	MBRSTS	1 = Active Insured 2 = Spouse 3 = Dependent			1	48	48	C	L	I,E
8	Plan Type	PLNTYP	1 = Indemnity 2 = PPO 3 = HMO 4 = POS 5 = Supplemental 6 = Ancillary			1	49	49	C	L	I,E
9	Product Type	PRDTYP	1 = Medical/ Health 2 = Ancillary Drug 3 = Ancillary Dental 4 = Ancillary Cancer 5 = Ancillary Hospital Confinement 6 = Other			1	50	50	C	L	I,E
10	Product Description	PRDDES	To Be Defined in Data Dictionary			1	51	51	C	L	I,E
11	Drug Coverage Indicator	DRGIND	Y = Yes N = No			1	52	52	C	L	I,E
12	Dental Coverage Indicator	DNTIND	Y = Yes N = No			1	53	53	C	L	I,E
13	Eligibility Period Starting Date	RPSDTE	CCYYMMDD	January 1, 2000	20000101	8	54	61	N	R	I,E
14	Eligibility Period Ending Date	RPEDTE	CCYYMMDD	March 31, 2000	20000331	8	62	69	N	R	I,E
15	Eligible Months in Reporting Period	ELGMOS	1 - 3 months (quarterly data)	calculated	calculated	2	70	71	N	R	I,E
16	Monthly Premium	MONPRM	Actual Dollar Amount	$1,234.56	123456	6.2	72	77	N	R	I,E
17	Max Individual Deductible (Fac)	MXIDEF	Actual Dollar Amount	$12,345	12345	5.0	78	82	N	R	I,E
18	Max Family Deductible (Fac)	MXFDEF	Actual Dollar Amount	$12,345	12345	5.0	83	87	N	R	I,E
19	Copay (Fac)	COPAYF	Actual Dollar Amount	$1,234,567	1234567	7.0	88	94	N	R	I,E
20	Coinsurance (Fac)	COINSF	Actual Percentage	12%	012	3.2	95	97	N	R	I,E
21	Max Individual Coinsurance (Fac)	MXICOF	Actual Dollar Amount	$12,345	12345	5.0	98	102	N	R	I,E
22	Max Family Coinsurance (Fac)	MXFCOF	Actual Dollar Amount	$12,345	12345	5.0	103	107	N	R	I,E
23	Max Individual Deductible (Prof)	MXIDEP	Actual Dollar Amount	$12,345	12345	5.0	108	112	N	R	I,E
24	Max Family Deductible (Prof)	MXFDEP	Actual Dollar Amount	$12,345	12345	5.0	113	117	N	R	I,E
25	Copay (Prof)	COPAYP	Actual Dollar Amount	$1,234,567	1234567	7.0	118	124	N	R	I,E
26	Coinsurance (Prof)	COINSP	Actual Percentage	12%	012	3.2	125	127	N	R	I,E
27	Max Individual Coinsurance (Prof)	MXICOP	Actual Dollar Amount	$12,345	12345	5.0	128	132	N	R	I,E
28	Max Family Coinsurance (Prof)	MXFCOP	Actual Dollar Amount	$12,345	12345	5.0	133	137	N	R	I,E
29	Max Individual Deductible (Other)	MXIDEO	Actual Dollar Amount	$12,345	12345	5.0	138	142	N	R	I,E
30	Max Family Deductible (Other)	MXFDEO	Actual Dollar Amount	$12,345	12345	5.0	143	147	N	R	I,E
31	Copay (Other)	COPAYO	Actual Dollar Amount	$1,234,567	1234567	7.0	148	154	N	R	I,E
32	Coinsurance (Other)	COINSO	Actual Percentage	12%	012	3.2	155	157	N	R	I,E
33	Max Individual Coinsurance (Other)	MXICOO	Actual Dollar Amount	$12,345	12345	5.0	158	162	N	R	I,E
34	Max Family Coinsurance (Other)	MXFCOO	Actual Dollar Amount	$12,345	12345	5.0	163	167	N	R	I,E
35	Max Individual Deductible (Comb)	MXIDEC	Actual Dollar Amount	$12,345	12345	5.0	168	172	N	R	I,E
36	Max Family Deductible (Comb)	MXFDEC	Actual Dollar Amount	$12,345	12345	5.0	173	177	N	R	I,E
37	Copay (Comb)	COPAYC	Actual Dollar Amount	$1,234,567	1234567	7.0	178	184	N	R	I,E
38	Coinsurance (Comb)	COINSC	Actual Percentage	12%	012	3.2	185	187	N	R	I,E
39	Max Individual Coinsurance (Comb)	MXICOC	Actual Dollar Amount	$12,345	12345	5.0	188	192	N	R	I,E
40	Max Family Coinsurance (Comb)	MXFCOC	Actual Dollar Amount	$12,345	12345	5.0	193	197	N	R	I,E
41	Drug Copay Amount- Generic	DGCOPG	Actual Dollar Amount	$12,345	12345	5.0	198	202	N	R	I,E
42	Drug Copay Amount- Brand Name	DGCOPB	Actual Dollar Amount	$12,345	12345	5.0	203	207	N	R	I,E
43	Drug Copay Percent	DGCOPP	Actual Percentage	12%	012	3.2	208	210	N	R	I,E
44	Drug Individual Deductible	DGIDED	Actual Dollar Amount	$12,345	12345	5.0	211	215	N	R	I,E
45	Drug Family Deductible	DGFDED	Actual Dollar Amount	$12,345	12345	5.0	216	220	N	R	I,E
46	Drug Individual Coinsurance	DGICOI	Actual Dollar Amount	$12,345	12345	5.0	221	225	N	R	I,E
47	Drug Family Coinsurance	DGFCOI	Actual Dollar Amount	$12,345	12345	5.0	226	230	N	R	I,E
48	Dental Individual Deductible (Basic)	DNIDE	Actual Dollar Amount	$12,345	12345	5.0	231	235	N	R	I,E
49	Dental Family Deductible (Basic)	DNFDE	Actual Dollar Amount	$12,345	12345	5.0	236	240	N	R	I,E
50	Dental Individual Coinsurance (Basic)	DNICO	Actual Dollar Amount	$12,345	12345	5.0	241	245	N	R	I,E
51	Dental Family Coinsurance (Basic)	DNFCO	Actual Dollar Amount	$12,345	12345	5.0	246	250	N	R	I,E
52	Dental Coinsurance Percent (Basic)	DNCOP	Actual Percentage	12%	012	3.2	251	253	N	R	I,E
53	Dental Individual Deductible (BL A)	DNIDEA	Actual Dollar Amount	$12,345	12345	5.0	254	258	N	R	I,E
54	Dental Family Deductible	DNFDEA	Actual Dollar Amount	$12,345	12345	5.0	259	263	N	R	I,E
55	Dental Individual Coinsurance (BL A)	DNICOA	Actual Dollar Amount	$12,345	12345	5.0	264	268	N	R	I,E
56	Dental Family Coinsurance (BL A)	DNFCOA	Actual Dollar Amount	$12,345	12345	5.0	269	273	N	R	I,E
57	Dental Coinsurance Percent (BL A)	DNCOPA	Actual Percentage	12%	012	3.2	274	276	N	R	I,E
58	Dental Individual Deductible (BL B)	DNIDEB	Actual Dollar Amount	$12,345	12345	5.0	277	281	N	R	I,E
59	Dental Family Deductible (BL B)	DNFDEB	Actual Dollar Amount	$12,345	12345	5.0	282	286	N	R	I,E
60	Dental Individual Coinsurance (BL B)	DNICOB	Actual Dollar Amount	$12,345	12345	5.0	287	291	N	R	I,E
61	Dental Family Coinsurance (BL B)	DNFCOB	Actual Dollar Amount	$12,345	12345	5.0	292	296	N	R	I,E
62	Dental Coinsurance Percent (BL B)	DNCOPB	Actual Percentage	12%	012	3.2	297	299	N	R	I,E
63	Dental Individual Deductible (BL C)	DNIDEC	Actual Dollar Amount	$12,345	12345	5.0	300	304	N	R	I,E
64	Dental Family Deductible (BL C)	DNFDEC	Actual Dollar Amount	$12,345	12345	5.0	305	309	N	R	I,E
65	Dental Individual Coinsurance (BL C)	DNICOC	Actual Dollar Amount	$12,345	12345	5.0	310	314	N	R	I,E
66	Dental Family Coinsurance (BL C)	DNFCOC	Actual Dollar Amount	$12,345	12345	5.0	315	319	N	R	I,E
67	Dental Coinsurance - Percent (BL C)	DNCOPC	Actual Percentage	12%	012	3.2	320	322	N	R	I,E
68	Dental Individual Deductible (BL D)	DNIDED	Actual Dollar Amount	$12,345	12345	5.0	323	327	N	R	I,E
69	Dental Family Deductible (BL D)	DNFDED	Actual Dollar Amount	$12,345	12345	5.0	328	332	N	R	I,E
70	Dental Individual Coinsurance (BL D)	DNICOD	Actual Dollar Amount	$12,345	12345	5.0	333	337	N	R	I,E
71	Dental Family Coinsurance (BL D)	DNFCOD	Actual Dollar Amount	$12,345	12345	5.0	338	342	N	R	I,E
72	Dental Coinsurance - Percent (BL D)	DNCOPD	Actual Percentage	12%	012	3.2	343	345	N	R	I,E
73	Benefit Payment per Day	BNPYPD	Actual Dollar Amount	$12,345	12345	5.0	346	350	N	R	I,E
74	Special Coverage Codes	SPECCD	To Be Defined in Data Dictionary	ABCD123	ABCD123	7	351	357	C	L	I

Patient Claim Record #1 Filename: CLMREC1 (Summary)

				DATA EXAMPLES		POSITION			FORMAT		
	ELEMENT	NAME	Valid Values	DISPLAY	SUBMITTED	LEN.	START	END	TYPE	JUST.	CONS.
1	Membership ID	MBRID	ID number of Member			20	1	20	C	L	I
2	Claim Number	CLMNO	Claim tracking number			18	21	38	C	L	I
3	Patient ID Number	PATNO	Last 4 digits of Patient Social Security Number			4	39	42	C	L	I
4	Patient Date of Birth	PATDOB	CCYYMMDD	December 31, 1999	19991231	8	43	50	N	R	I,E
5	Patient Gender Code	PATSEX	1 = Male 2 = Female			1	51	51	C	L	I,E
6	NAIC Number	NAICNO	NAIC number			5	52	56	C	L	I,E
7	Group Number	GRPNO				9	57	65	C	L	I
8	First Date of Service	FSTDS	CCYYMMDD	January 1, 2000	20000101	8	66	73	N	R	I,E
9	Last date of service	LSTDS	CCYYMMDD	February 28, 2000	20000228	8	74	81	N	R	I,E
10	Date paid	PDDTE	CCYYMMDD	March 31, 2000	20000315	8	82	89	N	R	I,E
11	Discharge Status	DISCHG	01 = Home 02 = to general short term hospital 03 = to skilled nursing facility 04 = to nursing facility 05 = to another type of institution for inpatient or outpatient 06 = to home under care of organized home health service organization 07 = Left Against Medical Advice 08 = Discharged/ transferred to home under care of home IV provider 09 = Admitted as inpatient in this hospital 20 = Expired 30 = Not Discharged 40 = Expired at Home 50 = Hospice – home 51 = Hospice – medical facility			2	90	91	C	L	I,E
12	Resident Zip code	RESZIP				5	92	96	C	L	I,E
13	Resident County	RESCOU				2	97	98	C	L	I,E
14	Member Status	MBRSTS	1 = Active Insured 2 = Spouse 3 = Dependent			1	99	99	C	L	I,E
15	Total Charges	TOTCHG	Actual Dollar Amount	$1,234,567.89	1234568790	10.2	100	109	N	R	I,E
16	Total Allowed	ALLCHG	Actual Dollar Amount	$1,234,567.89	1234568790	10.2	110	119	N	R	I,E
17	Total Paid	PDCHG	Actual Dollar Amount	$1,234,567.89	1234568790	10.2	120	129	N	R	I,E
18	ICD-9 Diagnosis Code	DIACDE	Primary Diagnosis Code	123.45	12345	5	130	134	C	L	I,E
19	ICD-9 Procedure Code	PRCCDE		12.34	1234	4	135	138	C	L	I,E
20	Coordination of Benefits	CBENF	1 = Primary 2 = Secondary 3 = Other			1	139	139	C	L	I,E
21	Claim line of Business	LOB	1 = Hospital Inpatient 2 = Hospital Outpatient 3 = Professional D = Drug			1	140	140	C	L	I,E

Patient Claim Record #2 Filename: CLMREC2 (Detail)

				DATA EXAMPLES		POSITION			FORMAT		
	ELEMENT	NAME	Valid Values	DISPLAY	SUBMITTED	LEN.	START	END	TYPE	JUST.	CONS.
1	Membership ID	MBRID	ID Number of member			20	1	20	C	L	I
2	Claim Number	CLMNO	Claim tracking number			18	21	38	C	L	I
3	Patient ID	PATNO	Last 4 digits of Patient SSN			4	39	42	C	L	I
4	Patient Date of Birth	PATDOB	CCYYMMDD	December 31, 1999	19991231	8	43	50	N	R	I,E
5	Patient Gender Code	PATSEX	1 = Male 2 = Female			1	51	51	C	L	I,E
6	Provider Type Code	PRVTYP	1 = Professional 2 = Institutional			1	52	52	C	L	I,E
7	Provider Number	PRVNUM	Hospital Medicare number others			10	53	62	C	L	I,E
8	Provider Location	PRVLOC	Primary practice Zip code			5	63	67	C	L	I,E
9	Provider Specialty	PRVSPC	Code Table 1A – 1D			3	68	70	C	L	I,E
10	Primary Diagnosis	PRIDIA	Left justified, no decimal point	123.45	12345	5	71	75	C	L	I,E
11	Secondary Diagnosis	SECDIA		123.45	12345	5	76	80	C	L	I,E
12	Third Diagnosis	THIDIA		123.45	12345	5	81	85	C	L	I,E
13	Increment/Line Item Number	LINENO	01-999			3	86	88	N	R	I,E
14	Revenue/Procedure Code	REVCDE	CPT-4 Codes HCPC Codes NDC codes for Pharmacy Revenue Codes			15	89	103	C	L	I,E
15	Modifier	REVMOD	1 = CPT - 4 Codes 2 = Revenue Codes 3 = HCPC Codes 4 = NDC Codes			1	104	104	C	L	I,E
16	Service Date	SERDTE	CCYYMMDD	January 2, 2000	20000102	8	105	112	N	R	I,E
17	Place of Service	SERPLC	See Code Table 2			2	113	114	C	L	I,E
18	Units of Service	SERUNT	days for inpatients, service units for			5.2	115	119	N	R	I,E
19	Type of Unit of Service	SERTYP	1 = minutes 2 = hours 3 = days 4 = quantity			1	120	120	C	L	I,E
20	Therapeutic Class Code	THRCLS	Assigned by KDHE	Leave blank	Leave blank	7	121	127	C	L	I
21	Brand Name Indicator	BRNDNM	1 = Brand Name 2 = Generic			1	128	128	C	L	I,E
22	Line Item Charge	LNCHG	Actual Dollar Amount	$132,456.78	13245678	8.2	129	136	N	R	I,E
23	Line Item Allowed	LNALL	Actual Dollar Amount	$132,456.78	13245678	8.2	137	144	N	R	I,E
24	Line Item Paid	LNPAID	Actual Dollar Amount	$132,456.78	13245678	8.2	145	152	N	R	I,E
25	Date Paid	DTPAID	CCYYMMDD	March 15, 2000	20000315	8	153	160	N	R	I,E
26	Capitation Indicator	CAPITN	Y = Yes N = No			1	161	161	C	L	I,E
27	Attending/Prescribing Provider	APPROV	Provider ID Number			10	162	171	C	L	I
28	Provider Type Code	APPTYP	1 = Attending Physician 2 = Prescribing Physician 3 = Pharmacy			1	172	172	C	L	I,E
29	Deductible	DEDUCT	Actual Dollar Amount	$1,234,567.89	123456789	9.2	173	181	N	R	I,E
30	Co-Insurance	COINS	Actual Dollar Amount	$1,234,567.89	123456789	9.2	182	190	N	R	I,E

Trailer File – Payer Name and Address Record Filename: Payer

				DATA EXAMPLES		POSITION			FORMAT		
	ELEMENT	NAME	Valid Values	DISPLAY	SUBMITTED	LEN.	START	END	TYPE	JUST,	CONS.
1	NAIC Number	NAICNO	NAIC Number			5	1	5	C	L	I,E
2	Payer Name					50	6	55	C	L	I
3	Address Line 1					50	56	105	C	L	I
4	Address Line 2					50	106	155	C	L	I
5	City					25	156	180	C	L	I
6	State					2	181	182	C	L	I
7	Zip Code					5	183	187	C	L	I
8	Payer Type		B = Blue Cross C =Commercial H = HMO S = Self Insured O = Other			1	188	188	C	L	I

APPENDIX C
KHIIS Data Submission Form

Kansas Health Insurance Information System Data Submission Form

Insurance Carrier Name
_____

NAIC Number(s)
_____

Reporting Period: _____ to _____

Submission Date:_____

Contact Person(s):

Name _____

Address _____

City, State, Zip _____

Phone _____

Email _____

Transmittal Type	**Character Set**	**Media:**
Please check one	Please check one	Please check one
___Original submission	___EBCDIC	___Reel Tape
___Re-submission	___ASCII	___8MM Cartridge
If re-submission Work order number:_____ Original submission date:_____		___2”Cartridge
		___3 2” Diskette
		___CD-ROM

Volume Number	4	8	12
1	5	9	13
2	6	10	14
3	7	11	15

File	**File Name**	**Number of Records**	**Record Length**	**Number of Bytes**
Header				
Membership				
Claim Rec 1				
Claim Rec 2				
Trailer				

Published 11/15/00
Revised

Appendix D
Data Assessment Checklist form

Kansas Health Insurance Information System
Data Assessment Checklist Form

Company:	
Reviewer:	
NAIC#:	
Review Date:	
Data Year	
Data Quarter	

Number of Records	Record Count	Rec. Length	Ave. Age	Item Response Scores		
Membership						
Summary						
Detail						
Matched						

Kansas Health Insurance Information System
Data Assessment Checklist Form

MEMBERSHIP RECORD #1 Filename: MBRSHP1 (Member and/or Ancillary)									
	ELEMENT	VAR NAME	FORMAT	CODING (Mean or Median)		FREQ. (N)	PERCENT	STATUS	SIGN
1	NAIC Number	NAICNO	5C	length					
2	Group Number	GRPNO	9C	length					
3	Membership ID	MBRID	20C	length					
4	Patient ID Number	PATNO	4C	length					
5	Patient Date of Birth	PATDOB	8N	CCYYMMDD					
6	Patient Gender Code	PATSEX	1C	1 – Male					
				2 – Female					
				0 – Missing or Mis-Coded					
7	Member Status	MBRSTS	1C	1 – Active Insured					
				2 – Spouse					
				3 – Dependent					
				0 – Missing or Mis-Coded					
8	Plan Type	PLNTYP	1C	1 – Indemnity					
				2 – PPO					
				3 – HMO					
				4 – POS					
				5 – Supplemental					
				6 – Ancillary					
				0 – Missing or Mis-Coded					
9	Product Type	PRDTYP	1C	1 – Medical/ Health					
				2 – Ancillary Drug					
				3 – Ancillary Dental					
				4 – Ancillary Cancer					
				5 – Ancillary Hospital Confinement					
				6 – Other					
				0 – Missing or Mis-Coded					
10	Product Description	PRDDES	1C	E – ERISA					
				S – Self Pay					
				0 – Missing or Mis-Coded					
11	Drug Coverage Indicator	DRGIND	1C	Y – Yes					
				N – No					
				0 – Missing or Mis-Coded					
12	Dental Coverage Indicator	DNTIND	1C	Y – Yes					
				N – No					
				0 – Missing or Mis-Coded					
13	Eligibility Period Starting Date	PRSDTE	8N	CCYYMMDD					
14	Eligibility Period Ending Date	PREDTE	8N	CCYYMMDD					
				mean	median/max	non-zero	% non-zero		
15	Eligible Months in Reporting Period	ELGMOS	2N						
16	Monthly Premium	MONPRM	6.2N						
17	Max Individual Deductible (Fac)	MXIDEF	5.0N						
18	Max Family Deductible (Fac)	MXFDEF	5.0N						
19	Copay (Fac)	COPAYF	7.0N						
20	Coinsurance (Fac)	COINSF	3.2N						
21	Max Individual Coinsurance (Fac)	MXICOF	5.0N						
22	Max Family Coinsurance (Fac)	MXFCOF	5.0N						
23	Max Individual Deductible (Prof)	MXIDEP	5.0N						
24	Max Family Deductible (Prof)	MXFDEP	5.0N						
25	Copay (Prof)	COPAYP	7.0N						
26	Coinsurance (Prof)	COINSP	3.2N						
27	Max Individual Coinsurance (Prof)	MXICOP	5.0N						
28	Max Family Coinsurance (Prof)	MXFCOP	5.0N						
29	Max Individual Deductible (Other)	MXIDEO	5.0N						
30	Max Family Deductible (Other)	MXFDEO	5.0N						
31	Copay (Other)	COPAYO	7.0N						
32	Coinsurance (Other)	COINSO	3.2N						
33	Max Individual Coinsurance (Other)	MXICOO	5.0N						
34	Max Family Coinsurance (Other)	MXFCOO	5.0N						

Kansas Health Insurance Information System
Data Assessment Checklist Form

MEMBERSHIP RECORD #1 Filename: MBRSHP1 (Member and/or Ancillary)									
	ELEMENT	VAR NAME	FORMAT	CODING (Mean or Median)		FREQ. (N)	PERCENT	STATUS	SIGN
				mean	**median/max**	**non-zero**	**% non-zero**		
35	Max Individual Deductible (Comb)	MXIDEC	5.0N						
36	Max Family Deductible (Comb)	MXFDEC	5.0N						
37	Copay (Comb)	COPAYC	7.0N						
38	Coinsurance (Comb)	COINSC	3.2N						
39	Max Individual Coinsurance (Comb)	MXICOC	5.0N						
40	Max Family Coinsurance (Comb)	MXFCOC	5.0N						
41	Drug Copay Amount- Generic	DGCOPG	5.0N						
42	Drug Copay Amount- Brand Name	DGCOPB	5.0N						
43	Drug Copay Percent	DGCOPP	3.2N						
44	Drug Individual Deductible	DGIDED	5.0N						
45	Drug Family Deductible	DGFDED	5.0N						
46	Drug Individual Coinsurance	DGICOI	5.0N						
47	Drug Family Coinsurance	DGFCOI	5.0N						
48	Dental Individual Deductible (Basic)	DNIDE	5.0N						
49	Dental Family Deductible (Basic)	DNFDE	5.0N						
50	Dental Individual Coinsurance (Basic)	DNICO	5.0N						
51	Dental Family Coinsurance (Basic)	DNFCO	5.0N						
52	Dental Coinsurance Percent (Basic)	DNCOP	3.2N						
53	Dental Individual Deductible (BL A)	DNIDEA	5.0N						
54	Dental Family Deductible	DNFDEA	5.0N						
55	Dental Individual Coinsurance (BL A)	DNICOA	5.0N						
56	Dental Family Coinsurance (BL A)	DNFCOA	5.0N						
57	Dental Coinsurance Percent (BL A)	DNCOPA	3.2N						
58	Dental Individual Deductible (BL B)	DNIDEB	5.0N						
59	Dental Family Deductible (BL B)	DNFDEB	5.0N						
60	Dental Individual Coinsurance (BL B)	DNICOB	5.0N						
61	Dental Family Coinsurance (BL B)	DNFCOB	5.0N						
62	Dental Coinsurance Percent (BL B)	DNCOPB	3.2N						
63	Dental Individual Deductible (BL C)	DNIDEC	5.0N						
64	Dental Family Deductible (BL C)	DNFDEC	5.0N						
65	Dental Individual Coinsurance (BL C)	DNICOC	5.0N						
66	Dental Family Coinsurance (BL C)	DNFCOC	5.0N						
67	Dental Coinsurance- Percent (BL C)	DNCOPC	3.2N						
68	Dental Individual Deductible (BL D)	DNIDED	5.0N						
69	Dental Family Deductible (BL D)	DNFDED	5.0N						
70	Dental Individual Coinsurance (BL D)	DNICOD	5.0N						
71	Dental Individual Coinsurance (BL D)	DNFCOD	5.0N						
72	Dental Coinsurance- Percent (BL D)	DNCOPD	3.2N						
73	Benefit Payment per Day	BNPYPD	5.0N						
74	Special Coverage Codes	SPECCD	7C						

Kansas Health Insurance Information System
Data Assessment Checklist Form

PATIENT CLAIM RECORD #1 Filename: CLMREC1 (Summary)								
	ELEMENT	VAR NAME	FORMAT	CODING	FREQ (N)	PERCENT	STATUS	SIGN
1	Membership ID	MBRID	20C	length				
2	Claim Number	CLMNO	18C	length				
3	Patient ID Number	PATNO	4C	length				
4	Patient Date of Birth	PATDOB	8N	CCYYMMDD (non-missing)				
5	Patient Gender Code	PATSEX	1C	1 = Male				
				2 = Female				
				0 = Missing or Mis-Coded				
6	NAIC Number	NAICNO	5N					
7	Group Number	GRPNO	9C	length				
8	First Date of Service	FSTDS	8N	CCYYMMDD				
9	Last date of service	LSTDS	8N	CCYYMMDD				
10	Date paid	PDDTE	8N	CCYYMMDD				
11	Discharge Status (Population for this variable includes patients identified as hospital inpatients as identified in Claim Line of Business (LOB), item 21 below.)	DISCHG	2C	01 = Home				
				02 = to general short term hospital				
				03 = to skilled nursing facility				
				04 = to nursing facility				
				05 = to another type of institution for				
				06 = to home under care of organized home				
				07 = Left AMA				
				08 = to home w/ home IV services				
				09 =admitted as inpatient to this hospital				
				20 = Expired				
				30 = Not Discharged				
				40 = Expired at Home				
				50 = Hospice (home)				
				51 - Hospice (medical facility)				
				0 = Missing or Invalid Coding				
12	Resident Zipcode	RESZIP	5C	valid Kansas zip code present				
				Missing, Mis-Coded, Out of State				
13	Resident County	RESCOU	2C	imputed from zip code				
14	Member Status	MBRSTS	1C	1 = Active Insured				
				2 = Spouse				
				3 = Dependent				
				0 = Missing or Mis-Coded				
				mean **median**	**non-zero**	**% non-zero**		
15	Total Charges	TOTCHG	10.2N					
16	Total Allowed	ALLCHG	10.2N					
17	Total Paid	PDCHG	10.2N					
18	ICD-9 Diagnosis Code	DIACDE	6C					
				0 = Missing or Mis-Coded				
19	ICD-9 Procedure Code	PRCCDE	6C					
				0 = Missing or Mis-Coded				
20	Coordination of Benefits	CBENF	1C	1 = Primary				
				2 = Secondary				
				3 = Other				
				0 = Missing or Mis-Coded				
21	Claim line of Business	LOB	1C	1 = Hospital Inpatient				
				2 = Hospital Outpatient				
				3 = Professional				
				D = Drug				
				0 = Missing or Mis-Coded				

Kansas Health Insurance Information System
Data Assessment Checklist Form

PATIENT CLAIM RECORD #2 Filename: CLMREC2 (Detail)									
	ELEMENT	VAR NAME	FORMAT	CODING (Mean or Median)		FREQ (N)	PERCENT	STATUS	SIGN
1	Membership ID	MBRID	20C	length					
2	Claim Number	CLMNO	18C	length					
3	Patient ID	PATNO	4C	length					
4	Patient Date of Birth	PATDOB	8N	CCYYMMDD					
5	Patient Gender Code	PATSEX	1C	1 = Male					
				2 = Female					
				0 = Missing or Mis-Coded					
6	Provider Type Code	PRVTYP	1C	1 = Professional					
				2 = Institutional					
				0 = Missing or Mis-Coded					
7	Provider Number	PRVNUM	10C	length					
8	Provider location	PRVLOC	5C						
9	Provider Specialty (N = # PRVTYP=1)	PRVSPC	3C	See Code Table 2					
10	Primary Diagnosis	PRIDIA	5C	ICD-9-CM code					
11	Secondary Diagnosis	SECDIA	5C						
12	Third Diagnosis	THIDIA	5C						
13	Increment/Line Item Number	LINENO	3N	01-999					
14	Revenue/Procedure Code	REVCDE	15C	CPT, HCPC, NDC, & Revenue Code					
15	Modifier	REVMOD	1C	1 = CPT - 4 Codes					
				2 = Revenue Codes					
				3 = HCPC Codes					
				4 = NDC Codes					
				0 = Missing or Mis-Coded					
16	Service Date	SERDTE	8N	CCYYMMDD					
17	Place of Service (N = # PRVTYP=2)	SERPLC	2C	Valid Places (See Code Table 3)					
18	Units of Service	SERUNT	5.2						
19	Type of Unit of Service	SERTYP	1C	1 = minutes					
				2 = hours					
				3 = days					
				4 = quantity					
				0 = Missing or Mis-Coded					
20	Therapeutic Class Code	THRCLS	7C	imputed from standard tables					
21	Brand Name Indicator (imputed from standard tables based on NDC Codes from Item 15 above)	BRNDNM	1C	1 = Brand Name					
				2 = Generic					
				0 = Missing or Mis-Coded					
				mean	**median**	**non-zero**	**% non-zero**		
22	Line Item Charge	LNCHG	8.2N						
23	Line Item Allowed	LNALL	8.2N						
24	Line Item Paid	LNPAID	8.2N						
25	Date Paid *	DTPAID	8N	CCYYMMDD					
26	Capitation Indicator	CAPITN	1C	Y = Yes					
				N = No					
				0 = Missing or Mis-Coded					
27	Attending/Prescribing Provider	APPROV	10C	length					
28	Attneding/Prescribing Provider Type Code	APPTYP	1C	1 = Attending Physician					
				2 = Prescribing Physician					
				3 = Pharmacy					
				0 = Missing or Mis-Coded					
				mean	**median**	**non-zero**	**% non-zero**		
29	Deductible	DEDUCT	9.2N						
30	Co-Insurance	COINS	9.2N						

Appendix E
Data Request Forms

Form RD-3INS
Rev. 7/2000

Kansas Insurance Department
Accident and Health Division
900 SW Jackson Street, Room 904N
Topeka, Kansas 66612-1220
Phone (785) 368-7394 ** Fax (785) 368-7118

Public-Use Data Request Form

Name: _____

Organization: _____ Kind of Business: _____

Address: _____

Phone number: (_____) _____ Fax number: (_____) _____

1. What type of data would you like to obtain? _____

2. What is the purpose of this data request? _____

3. Brief description of the level of detail of data requested. _____

4. Format needed:
_____Hard copy (paper, mailed or faxed if 5 pages or less) _____CD Rom _____3.5 inch disk _____ZIP Disk _____Labels

5. How would you like data provided? By mail, fax, pick-up, Fedex-COD _____
(Please Specify)

I understand that the data provided by the Kansas Insurance Department through the Kansas Department of Health and Environment will not be used for the purpose of selling or offering for sale any property or service to any person listed or to any person who resides at any address listed; or to sell, give or otherwise make available to any person any list of names or addresses for sale of property or service to any person listed or to any person who resides at any address listed, K.S.A. 45-220. Violation of this provision is a criminal misdemeanor, K.S.A. 21-3914. I understand that the data provided by the Center for Health and Environmental Statistics will not be released or provided to other data users in a manner that will identify individuals. I also understand that breach of the confidentiality agreement in KAR 28-67-4 will result in immediate termination of future data provisions and is a Class C misdemeanor punishable by law.

_____

Signature Title Date

Kansas Department of Health and Environment use only.

Tracking Number _____

Date request received: _____
(Date) (Staff Initials)

Date request fulfilled: _____
(Date) (Staff Initials)

Fee charged: _____

Check one:

___Data provided as requested
___Modification of request

Explain _____
_____
_____
_____

A. Request Apprv/Denied by KDHE _____
(Date) (Initials)

Request Apprv/Denied by KID _____
(Date) (Initials)

Appealed to Commissioner _____
(Date)

B. Commissioner approval sought ___Yes ___No

Commissioner Approval _____
(Date) (Commissioner's Initials)

Commissioner Denied _____
(Date) (Commissioner's Initials)

Form RD-3INS
Rev. 7/2000

Kansas Insurance Department
Accident and Health Division
900 SW Jackson Street, Room 904N
Topeka, Kansas 66612-1220
Phone (785) 368-7394 ** Fax (785) 368-7118

Restricted-Use Data Request Form

Name: _____ Organization: _____

Address: _____ Kind of Business _____

Phone number: (_____) _____ Fax number: (_____) _____

Please complete the following questions for restricted-use data (use additional sheets if necessary).

1. Brief description of the project or Study Proposed: _____

2. Purpose of the project or study: _____

3. Description of the data elements needed for the project or study: _____
_____

4. Has this project or study protocol been approved by an internal review board? ___Yes ___No ___N/A

5. a. Description of the data security procedures you or your organization will follow complete with who has responsibility for security of the data: _____
   b. Who has access to the data? _____

6. a. Description of the proposed use and/or release of the data: _____
   _____
   b. If data are to be released, how? _____

Format needed:

____Hard copy (paper, mailed or faxed If 5 pages or less) ____CD Rom ____3.5 inch disk ____ZIP Disk ____Labels

I understand that the data provided by the Kansas Insurance Department through the Kansas Department of Health and Environment will not be released or provided to other data users in a manner that will identify individuals. I also understand that breach of the confidentiality agreement in KAR 28-67-4 will result in immediate termination of future data provisions and is a Class C misdemeanor punishable by law. I understand that the data provided by the Center for Health and Environmental Statistics will not be released or provided to other data users in a manner that will identify individuals. I also understand that breach of the confidentiality agreement in KAR 28-67-4 will result in immediate termination of future data provisions and is a Class C misdemeanor punishable by law.

_____

Requester Date Department Head Date

Kansas Department of Health and Environment use only.

Tracking Number _____

Date request received: _____
(Date) (Staff Initials)

Date request fulfilled: _____
(Date) (Staff Initials)

Fee charged: _____

Check one:

___Data Provided as Requested
___Modification of Request

Explain _____
_____
_____
_____

A. Request Apprv/Denied by KDHE _____
(Date) (Initials)

Request Apprv/Denied by KID _____
(Date) (Initials)

Appealed to Commissioner _____
(Date)

B. Commissioner approval sought ___Yes ___No

Commissioner Approval _____
(Date) (Commissioner's Initials)

Commissioner Denied _____
(Date) (Commissioner's Initials)

Appendix F
Code Tables

CODE TABLE 1A
PHYSICIANS

	Principal Specialty	Sub-Specialties	Code
1	Aerospace Medicine	Aerospace medicine	AM
2	Allergy and Immunology	Allergy and Immunology Clinical and Laboratory Immunology	AI
3	Anesthesiology	Anesthesiology Critical Care Medicine Pain Management	AN
4	Colon and Rectal Surgery	Colon and Rectal Surgery	CRS
5	Dermatology	Dermatology	DE
6	Dermatology and Pathology	Dermatopathology	DMP
7	Emergency Medicine	Emergency Medicine	EM
8	Experimental Program	Experimental Program	EX
9	Family Practice	Family Practice General Practice Geriatric Medicine	FP
10	General Surgery	Abdominal Surgery Critical Care Hand Surgery Pediatric Surgery Surgery - General Vascular Surgery	GS
11	Internal Medicine	Cardiovascular Disease Critical Care Medicine Endocrinology, Diabetes, and Metabolism Gastroenterology Geriatric Medicine Hematology Hematology and Oncology Infectious Disease Internal Medicine Nephrology Oncology Pulmonary Disease Rheumatology	IM
12	Neurological Surgery	Neurological Surgery Pediatric Neurological Surgery	NS
13	Neurology	Child Neurology Neurology	NE
14	Nuclear Medicine	Nuclear Medicine	NM
15	Obstetrics and Gynecology	Obstetrics and Gynecology	OBG
16	Ophthalmology	Eye Surgery Ophthalmology	OPH

	Principal Specialty	Sub-Specialties	Code
17	Orthopedic Surgery	Adult Reconstructive Orthopedics Hand Surgery (Limited to Orthopedics) Musculoskeletal Oncology Orthopedic Sports Medicine Orthopedic Surgery Orthopedic Surgery of the Spine Orthopedic Trauma Pediatric Orthopedics Spine Surgery Sports Medicine	OS
18	Otolaryngology	Ophthalmology Otology Laryngology Otolaryngology Rhinology	OT
19	Pathology	Anatomic and Clinical Pathology Blood Banking/Transfusion Medicine Chemical Pathology Cytopathology Dermatopathology Forensic Pathology Hematology Immunopathology Medical Microbiology Neuropathology Pathology Pathology-Selective	PA
20	Pediatrics	Critical Care Medicine Neonatal-Perinatal medicine Pediatrics Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Nephrology Pediatric Pulmonology	PD
21	Physical Medicine and Rehabilitation	Physical Medicine and Rehabilitation	PM
22	Plastic Surgery	Hand Surgery (Limited to plastic surgery) Plastic Surgery	PS
23	Preventive Medicine	Preventive Medicine	GPM

	Principal Specialty	Sub-Specialties	Code
24	Psychiatry	Child and Adolescent Psychiatry Geriatric Psychiatry Psychiatry	PY
25	Radiation Oncology	Radiation Oncology	RO
26	Radiology-Diagnostic	Neuroradiology Nuclear Radiology Pediatric Radiology Radiology-Diagnostic Vascular and Interventional Radiology	DR
27	Thoracic Surgery	Thoracic Surgery	TS
28	Urology	Pediatric Urology Urology	UR
29	Medical Doctor	Specialty Unspecified	MD

CODE TABLE 1B
OSTEOPATHS

	Principal Specialty	Sub-specialties	Code
1	Osteopathic Physician	Manipulative Therapy	OMT
2	Osteopathic Physician	Obstetrics	OOB
3	Osteopathic Physician	Pathology	OPA
4	Osteopathic Physician	Neurology Psychiatry	ONP
5	Osteopathic Physician	Radiology Roentgenology	ORR
6	Osteopathic Physician	Specialty Unspecified	DO

CODE TABLE 1C
OTHER MEDICAL PERSONNEL

	Principal Specialty	Sub-specialties	Code
1	Acupuncturist	Acupuncturist	ACU
2	Advanced Registered Nurse Practitioner	Clinical Nurse Specialist	CNS
3	Advanced Registered Nurse Practitioner	Nurse Midwife	PNM
4	Advanced Registered Nurse Practitioner	Nurse Clinical/Nurse Practitioner	NCP
5	Audiology	Audiology	PAU
6	Cardiac Rehabilitation	Cardiac Rehabilitation	CRP
7	Certified Registered Nurse Anesthetist	Certified Registered Nurse Anesthetist	CNA
8	Chiropractor	Chiropractor	CHI
9	Dentistry	Endodontics General Dentistry Orthodontics Oral Surgery Pediatric Dentistry Periodontics	DEN
10	Dietician	Dietician	DT
11	Emergency Services	Emergency Medical Technician Mobile Intensive Care Technician Emergency Medical Technician-Intermediate Emergency Medical Technician-Defibrillator First Responder	EMS
12	Licensed Clinical Social Worker	Licensed Clinical Social Worker	CSW
13	Licensed Practical Nurse	Licensed Practical Nurse	LPN
14	Medical Microbiology	Medical Microbiology	MM
15	Mental Health Technician	Mental Health Technician	MHT
16	Naturopathy/Naturopath	Naturopathy/Naturopath	NAU
17	Nephrology/Dialysis	Nephrology/Dialysis Providers	NDP
18	Non-Medical	Attorney Legal Medicine	NMP
19	Optometry	Optometry	OPT
20	Other	Multiple Providers Other Public Health	OTR
21	Physician Assistant	Physician Assistant	PAS
22	Podiatry Surgical Chiropody	Podiatry Surgical Chiropody	PSC

	Principal Specialty	Sub-specialties	Code
23	Psychology	Applied Behavioral Analysis Behavioral Clinical Clinical Neuropsychology Counseling Developmental Educational Experimental General Industrial Neuropsychology Organizational Religious School Social	PSY
24	Registered Nurse	Registered Nurse	RN
25	Therapy	Occupational Therapy	OTH
26	Therapy	Physical Rehabilitation Therapy	PRT
27	Therapy	Speech Therapy	SPT
28	Therapy	Respiratory Therapy	RT

CODE TABLE 1D
MEDICAL SUPPLIES

	Principal Specialty	Sub-specialties	Code
1	Durable Medical Equipment	Durable Medical Equipment	DME
2	Hearing Aid Dispenser	Hearing Aid Dispenser	HAD
3	Optical Dispenser	Optical Dispenser	OD
4	Pharmacy	Pharmacy	PHA

CODE TABLE 2
PLACE OF SERVICE

Code	Place	Definition
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or Local Public Health Clinic or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room-Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

Code	Place	Definition
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services which does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disable, or sick persons or on a regular basis health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board or other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance-Land	A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
42	Ambulance Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
50	Federally-Qualified Health Center	A facility located in a medically undeserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible form outpatient visits in a hospital-based or hospital affiliated facility.

Code	Place	Definition
53	Community Mental Health Center	A facility that provides the following services: • Outpatient services including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; • 24-hour a day emergency services; • Day treatment, other partial hospitalization services, or psychosocial rehabilitation services; • Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admissions; and • Consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care of treatment available in a hospital or SNF.
55	Residential Substance Abuse Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs, and supplies, psychological testing and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitation nursing, physical therapy, occupational therapy, speech pathology, social of psychological services, and orthotics and prosthetics services.

Code	Place	Definition
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitation nursing, physical therapy occupational therapy, speech pathology, social and psychological services and orthotics and prosthetics services.
65	End Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance and/or training to patients or care givers on an ambulatory of home-care basis.
71	State of Local Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution of a physicians office.
99	Other Unlisted Facility	Other service facilities not identified above.